



Regional Technical Assistance Report

Project Number: 41480
May 2008

Equity in the Delivery of Public Services in Selected Developing Member Countries

Asian Development Bank

ABBREVIATIONS

ADB	–	Asian Development Bank
DMC	–	developing member country
ERD	–	Economics and Research Department
RETA	–	regional technical assistance
TA	–	technical assistance

TECHNICAL ASSISTANCE CLASSIFICATION

Targeting Classification	–	General intervention
Sectors	–	Multisector (education; health, nutrition, and social protection)
Subsectors	–	Basic education, education sector development, health programs, health systems
Theme	–	Inclusive social development
Subtheme	–	Human development

NOTE

In this report, "\$" refers to US dollars.

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I. INTRODUCTION

1. Improving the delivery of public services in the Asia and Pacific region is part of the enhanced poverty reduction strategy of the Asian Development Bank (ADB). Effective delivery and equitable access to public services are essential for broadening inclusiveness of growth and reducing poverty and inequality. The regional technical assistance (RETA) study, *Equity in the Delivery of Public Services in Selected Developing Member Countries (DMCs)*, fits into a core strategic priority of ADB's medium-term strategy II (2006–2008) to strengthen inclusiveness. The RETA aims to increase understanding of the performance of public services, as well as the policy challenges and constraints to improving the delivery of these services in selected DMCs. Based on this improved understanding, the study will develop a framework for identifying appropriate interventions to improve the delivery of public services that will suit individual country circumstances. Four DMCs will be selected for inclusion in the RETA. While public services encompass a broad range of elements to ensure people's well-being, the RETA will focus on services with direct linkages to improving education and health outcomes: education and health services, and infrastructure services such as those concerning water and sanitation. On 6 July 2007, ADB's vice president (knowledge management and sustainable development) approved a concept paper prepared for the RETA project. The draft design and monitoring framework is in Appendix 1.¹

II. ISSUES

2. The delivery of basic public services is central to reducing poverty. Poor people list water, education, health care, and personal security needs as their highest priorities.² Expanding inclusive service delivery is pivotal to achieving the Millennium Development Goals. Although the provision of basic education and health services is largely the responsibility of governments, the private sector also has an important role. But since the provision of such services is replete with market failures or externalities; the private sector would not likely be able to achieve the level of education and health that society expects. More importantly, education and health services are deemed fundamental human rights. This suggests that regardless of the role played by the private sector, the public sector should be largely responsible for education and health of the people (the so-called merit goods argument). Thus studying how the government can assume this fundamental responsibility in a satisfactory manner is of critical importance. A key dimension of public service delivery is equity.

3. Equity has long been an important goal of education and health sectors. Yet, inequalities between the poor and the better-off persist. In the 1980s, governments typically were more interested in addressing cost constraints and improving efficiency than in promoting equity. By the end of the 1990s, many governments and international organizations were prioritizing equity in their development agendas. This emphasis continued into the new millennium, and governments are increasingly focusing on policies and programs to reduce inequities. Equity of public service delivery can be assessed by evaluating (i) accessibility; (ii) utilization; (iii) quality; and (iv) the progressive nature and redistributive effect of public spending (para. 7), including leakage of funds.

¹ The TA first appeared in the business opportunities section of ADB's website on 23 November 2007.

² Narayan, D., R. Chambers, M. K. Shah, and P. Petesch. 2000. *Voices of the Poor: Crying Out for Change*. New York: World Bank/Oxford University Press.

4. **Accessibility.** In many low income DMCs, access to schools, health clinics, clean water, sanitation facilities, and other services is limited. While available services may vary vastly from one country to another, the rich tend to have better access than the poor. In some countries, the poor need to travel farther to reach education and health services than do the rich. In Nepal, the poorest 20% of the population needs to travel more than two times farther the richest 20% to reach the nearest schools, more than two times farther to reach the nearest health centers, and more than three-and-a-half times farther to reach the nearest market centers.

5. **Utilization.** The exact relationship between utilization of public services and prices or family income varies across individuals. For poor people, less utilization is often associated with low income and high prices. The poor spend a large proportion of their money on public services. In low-income countries, 80% of health spending is private; in middle-income countries, the share is 50%.³ Moreover, the poor often need to pay more for the same goods and services. For example, they often pay higher prices to water sellers than the better-off pay to utilities. In Pune, India, low-income households pay many times more than the price of metered water used by middle- and upper-income households.

6. **Quality.** In developing countries, public services are often of low quality even if they are accessible and affordable. As a result, many poor people bypass the closest public facilities to go to more expensive private facilities or choose better quality at more distant facilities. The lack of accountability, weak supervision, high politicization, and fiscal constraints are considered serious impediments to the delivery of quality education and health services in Asia. Empirical evidence of teacher or health worker absenteeism in some parts of Asia indicates poor quality public services.⁴ The technical quality of services is also an important element to ensure effective delivery of public services: services can fail the poor when inputs are combined to produce ineffective or inefficient outcomes. Quality of public services is also determined by their responsiveness to clients. Services should be provided to those who are in need, irrespective of their economic and social status. Recently the gap between the poor and rich in access to and utilization of quality education and health services has been growing rapidly, particularly with the increasing role of the private sector that caters only to those who have the ability to pay.

7. **Progressivity and Redistributive Effect of Public Finance.** Education and health spending accounts for about 33% of total public expenditure; 25% for low-income countries and 29% for middle-income countries (footnote 3). Governments contribute a large share of the financing for schools and clinics. In this regard, the public sector is a major provider as well as a funding source of education and health services. A question then arises as to the extent to which payments for education and health care are related to the ability to pay. Is this relationship proportional? Or is it progressive, i.e., do payments for education and health care account for an increasing proportion of ability to pay as the ability to pay rises? Is this relationship regressive, in the sense that payments comprise a decreasing share of the ability to pay? Progressivity is measured in regard to departure from proportionality in the relationship between payments toward provision of public services and ability to pay. The relationship between progressivity and the redistributive impact of service payments also needs to be investigated. Redistribution can be vertical and horizontal. Vertical redistribution occurs when payments are disproportionately related to the ability to pay. Horizontal redistribution occurs when people with equal ability to pay contribute unequally to the payments for services.

³ World Bank. 2007. *World Development Indicators*. Washington, DC.

⁴ A number of studies have examined the problem of absence among education and health providers in India and Indonesia. A recent study is: Chaudhury, N., J. Hammer, M. Kremer, K. Muralidharan, and F. H. Roger. 2006. Missing in Action: Teacher and Health Worker in Developing Countries. *Journal of Economic Perspective* 20(1): 91–116.

8. **Leakage and Targeting.** The belief that increasing budgetary resources will automatically improve the delivery of basic services in education and health is widely accepted. However, a growing body of studies demonstrates that allocating more budgetary resources to these sectors will not necessarily deliver better outcomes. Public spending may have little impact on the education and health status of individuals if public expenditures do not translate into improved services due to leakage of funds. Public resources may not adequately measure the availability of effective services in a context where mismanagement, rent-seeking activities, corruption, and poor targeting thrive. Significant differences could occur between official spending in a sector, and actual spending by the provider because of capture and leakages of funds at various layers of the political and administrative systems. This in turn calls for well-targeted policy intervention to ensure public services do reach the people, particularly the poor and vulnerable.

9. ADB has completed a number of technical assistance and RETA projects in relation to public service delivery (Supplementary Appendix A, available on request), but these are largely confined to issues of decentralization and governance. Beyond these issues, this RETA will provide qualitative and quantitative analysis of public service delivery, with a particular focus on education and health equity in selected DMCs. Findings that emerge from the RETA could be useful for ADB operations as well as government policy making.

III. THE TECHNICAL ASSISTANCE

A. Impact and Outcome

10. The RETA is expected to improve the capacity of DMCs to make informed decisions on policy and reforms required for better delivery of public services. The outcome is improved knowledge on (i) the performance of public service delivery in DMCs, (ii) the constraints to improving the delivery of public services, and (iii) policy challenges.

B. Methodology and Key Activities

11. The RETA will draw on various approaches and methodologies used in education, health economics, and public finance. Along with the suggested methodologies, the RETA will explore relevant key variables and questions (Appendix 2). The draft outline of the contents for the report is provided in Supplementary Appendix B (available on request).

12. **Key Variables.** The RETA will focus on variables, including (i) education and health outcomes within and across countries; (ii) access to and utilization of quality education and health care; (iii) subsidies received through the use of services; (iv) payments people make for education and health care—directly through out-of-pocket payments as well as indirectly through insurance premiums, social insurance contributions, and taxes; and (v) policy interventions for effective service delivery. For variables (i) to (iii), the RETA will explore the magnitude of inequality between the poor and the better-off. In the case of variable (iv), it will seek to establish to whom the benefits of government spending accrue, with recipients being ranked by their relative economic position. It will examine the distribution of average spending and consider the benefit incidence of marginal dollars spent on education and health care. This issue is also related to the importance of government resource leakages in education and health funds, which can deter effective service delivery. In this context, the RETA will pay particular attention to progressivity; the incidence of catastrophic payments in the health sector; incidence of impoverishing payments (i.e., those that cause a household to cross the poverty threshold);

as well as defining and quantifying leakages. Variable (v) is concerned with evaluating a particular policy intervention that is ongoing or will soon be implemented. More specifically, the RETA will investigate the impact of conditional cash transfers on poverty reduction, health and nutritional status of children from poor families, and school attendance. Targeting related issues—such as targeting methods, exclusion and inclusion errors, administrative costs, and identification of beneficiaries using nonincome indicators—are of great relevance to ADB operations and will be investigated in the RETA. Such issues are extremely important for designing and implementing social policies.

13. **Tools.** The questions that the RETA seeks to answer require quantitative analysis that demands a few key ingredients. First, suitable data sets are needed. Since the analysis involves comparing individuals or households in different socioeconomic circumstances, the data for education and health equity analysis will be mainly household surveys that are already available. In addition, data on public spending on education and health—for both central and local governments—will be required. Consultations will be conducted with central and local governments. Second, the definition and measurement of key variables will be clarified, including education and health outcomes, service utilization, service needs, subsidies, payments, and living standards. Third, the RETA will need a set of quantitative methods to measure inequality in education and health, progressivity of payments for public services, incidence and intensity of catastrophic payments, and incidence of impoverishing payments. Impact evaluation methods will be utilized for program evaluation.

14. Key activities of the RETA are (i) country-specific inception workshops, (ii) a regional conference to disseminate findings of country studies, (iii) publication of country studies and comparative analyses in journals or books, and (iv) external press releases. The inception workshop will include participants from the concerned ministries and the selected consultants for the country study. It will discuss refinements to the suggested methodologies by each team tasked to handle the country case studies.

15. Under the RETA, ADB's Economics and Research Department (ERD) will prepare two background papers. One paper will investigate inequalities in health and education from outcome indicators across the Asia and Pacific region over time. It will develop a new index that captures the disparity in economic and noneconomic welfare of individual countries, as well as aggregate welfare of all the countries in the region. This will intend to show inequality between countries. The second paper will consider methodological issues relating to the measurement of equity in health and education. It will also deal with the trade-off between equity and efficiency.

C. Cost and Financing

16. The RETA is estimated to cost \$500,000. It will be financed on a grant basis by ADB's technical assistance funding program. The proceeds will cover consulting services, country visits, workshops, data purchase, in-depth studies, equipment, and administration and support costs. The cost estimates and financing plan are in Appendix 3.

D. Implementation Arrangements

17. ADB will implement the RETA in two stages in partnership with relevant in-country research institutions or individuals, and in coordination with relevant government agencies in the participating DMCs. The Philippines and Nepal will be the participating DMCs in the first stage, the former representing a middle-income country and the latter a low-income country. Another consideration in country selection is data availability. Two more participating countries will be

selected for the second stage, in consultation with regional departments. ERD will administer the RETA in close coordination with the country teams in the regional departments of the participating countries. A no-objection will be obtained from the relevant DMCs prior to starting any activities under the RETA. The RETA will be implemented from June 2008 to December 2009.

18. The RETA will require an estimated total of 50 person-months of consulting services (15 person-months international and 35 person-months national). ERD will set up a technical advisory panel of experts who will provide methodological or technical guidance and strategic directions to the project. ADB will engage all consultants as individuals or as firms in accordance with the *Guidelines on the Use of Consultants* (2007, as amended from time to time). An outline of the terms of reference for consultants is in Appendix 4.

19. For each participating country, a team will be formed to carry out the study. Each team will submit three reports: (i) an inception report no later than 4 weeks following commencement of services; (ii) a draft report at the end of the 6th month; and (iii) a final report within 4 weeks of receiving comments on the draft report from the ADB and peer groups. Based on the country reports, the project team will produce a final report highlighting the key findings of the RETA study to facilitate policy reviews by governments and stakeholders.

20. The findings of the RETA studies will be disseminated through seminars, inception and finalization workshops, publications in professional journals and books, and press releases.

21. ADB will procure equipment (computer hardware and software) in accordance with its *Procurement Guidelines* (2007, as amended from time to time). Procurement will be coordinated with ADB's Office of Information Systems and Technology and Office of Administrative Services. After the RETA, any procured equipment will be disposed of in accordance with the project administration instructions on administering grant-financed technical assistance.⁵

IV. THE PRESIDENT'S DECISION

22. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$500,000 on a grant basis for Equity in the Delivery of Public Services in Selected Developing Member Countries, and hereby reports this action to the Board.

⁵ ADB. 2008. *Project Administration Instructions*. No. 5.11: Administering Grant-Financed Technical Assistance Projects. Manila (January).

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>Impact Improved capacity of DMCs to make informed decisions on policy and reforms required for better delivery of health and education services</p>	<p>Visible improvements in key indicators for education, health, and basic infrastructure for DMCs</p>	<p>DMCs' annual development, education, and health reports</p>	<p>Assumption</p> <ul style="list-style-type: none"> • Willingness of policy makers in the DMCs to base their medium- to long-term policies on inclusive development
<p>Outcome Improved knowledge on performance of public services delivery in DMCs</p>	<p>A number of DMCs undertake appropriate interventions to address effective and equitable delivery in education and health services</p>	<p>Country operations business plans, and approved TA reports</p>	<p>Assumption</p> <ul style="list-style-type: none"> • Appropriate policy interventions identified under the RETA effectively disseminated to the DMCs not covered by the RETA <p>Risk</p> <ul style="list-style-type: none"> • Weak capacity of the DMCs to enforce such policy interventions
<p>Outputs Stage 1: Conduct two country studies for the Philippines and Nepal</p> <p>Stage 2: Conduct remaining two country studies</p>	<p>Country studies for Nepal and the Philippines completed by January 2009</p> <p>Two in-country workshops held by August 2008</p> <p>Country studies for two more participating countries (to be selected after the completion of the first two) completed by July 2009</p> <p>Two in-country workshops by March 2009</p> <p>One regional workshop organized by August 2009</p> <p>Final report completed by October 2009</p>	<p>Economics and Research Department publications, RETA performance report, and project information document</p>	<p>Assumptions</p> <ul style="list-style-type: none"> • Access to high-quality data on household, health, and demographic surveys, and public finance for participating DMCs • Availability of institutions and individual experts with familiarity and knowledge of the selected DMCs <p>Risk</p> <ul style="list-style-type: none"> • Identified policy interventions may not be appropriate for all DMCs

Activities with Milestones	Inputs
Stage 1	ADB: \$500,000
1.1 Core team of experts mobilized (April–May 2008)	
1.2 RETA website established (May–June 2008)	15 person-months of international and 35 person-months of national consulting services
1.3 Country studies for the Philippines and Nepal (August 2008–January 2009)	
Stage 2	
2.1 Methodology revisited based on experiences gained from the Philippines and Nepal studies (January–February 2009)	Consultants: \$380,000
2.2 Two remaining DMCs selected in consultation with the regional departments (February–March 2009)	International and local travel: \$20,000
2.3 Country studies for the two selected DMCs (April–July 2009)	Reports and communications: \$10,000
2.4 Final comparative study report (October 2009)	Equipment: \$ 5,000
	Seminars and conferences: \$20,000
	Data purchase: \$10,000
	Miscellaneous administration \$5,000
	Contingencies \$50,000

ADB = Asian Development Bank, DMC = developing member country, RETA = regional technical assistance, TA = technical assistance.

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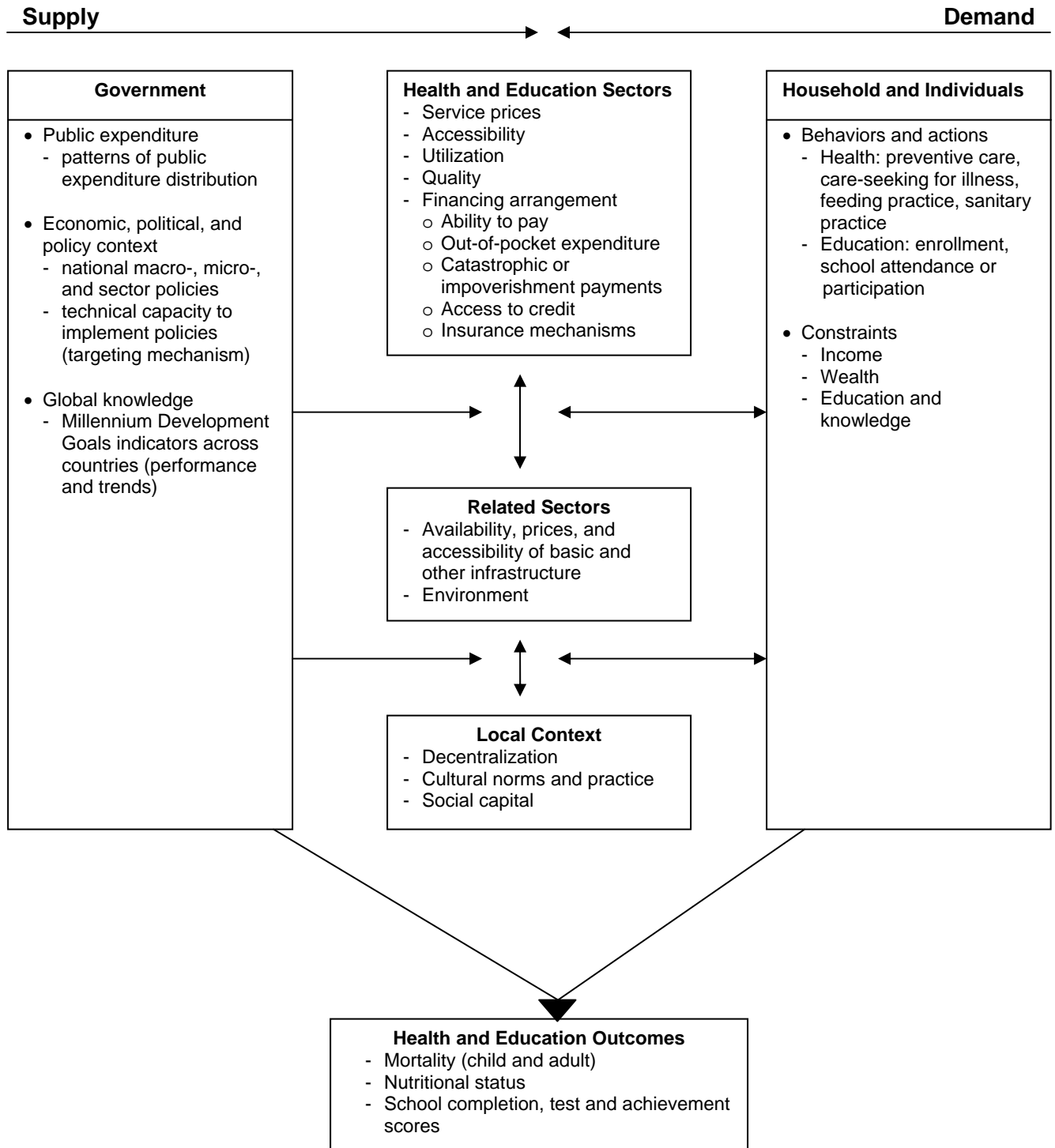
KEY VARIABLES, QUESTIONS, AND SUGGESTED METHODOLOGY

Key Variables	Key Questions	Methodology	Data
Cross-Country Analysis	Are inequalities in health and education indicators (e.g., net enrollment rates, child mortality rates) in country A larger than in country B? Are inequalities larger now than previously? More specifically, were inequalities in health and education indicators larger in the 1990s than in the 1980s? Can a relationship be identified between inequality in income and inequalities in nonincome education and health indicators? Is the relationship between the level of development and inequality in such nonincome indicators positive or negative?	A new index will be developed to capture the disparity in economic welfare for individual countries as well as aggregate welfare of all countries in Asia. The index will be estimated for both income and nonincome indicators. This measure also takes into account inequality between countries. The analysis will be done across countries and over time.	World Development Indicators; ADB key indicators for various years
Equity in Health and Education: Measurement Issues	What is equity? How can equity be defined using a social welfare function? What are the measures of equity? What are their relative strengths and weaknesses? Is an alternative measure of equity available that takes into account weaknesses of existing measure(s)? How can equity be explained in terms of socioeconomic and demographic characteristics?	For this purpose, various proposed measures of equity will be critically evaluated and assessed in terms of their strengths and weaknesses. An alternative measure could be developed taking into account the trade-off between equity and efficiency in health and education service delivery. The proposed equity measure will then be explained using a decomposition methodology involving various socioeconomic and demographic factors of households.	World Health Organization surveys and education surveys
Within Country Analysis (i) Explain inequalities in outcomes, access to, and quality of health and education services	Do inequalities in education and health outcomes between the poor and better-off exist? Does access to and utilization of health and education services vary significantly between the poor and nonpoor? If yes, then by how much? What inequalities generate inequalities in the variables of interest? For instance, child survival inequalities are likely to reflect such inequalities as inequality in education, health insurance coverage, and utilization of health services. How significant is each of these inequalities and what is its relative	Various methods could explain inequalities in outcomes, access to, and utilization of health and education services. Of those, the RETA proposes to use the opportunity curve and opportunity index. This method estimates (i) average for the population and (ii) how services are accessed and utilized by the population. In addition, a regression analysis will be used to identify factors that explain inequalities in outcomes and service utilization across	Household surveys, demographic and health surveys, data on government expenditure on health and education

<p>(ii) Assess equity in public spending on education and health</p> <p>(iii) Identify constraints to effective service delivery</p>	<p>contribution to explaining the observed inequalities in health and education outcomes?</p> <p>Is public resource allocation and public service provision to the population efficient and equitable? Is public resource allocation biased against a certain socioeconomic and geographic group? How is public spending on health and education financed? Is it mainly by tax revenues or by out-of-pocket payments? What are the tax policy implications for making service delivery more pro-poor? Are subsidies to the education and health sectors targeted at the poor as intended?</p> <p>Does the method of delivering public services matter? Is public resource leakage quantifiable? If corrected for leakages, would access to and quality of basic services improve? Do incentive systems matter for effective service delivery? Is poor targeting a cause of failing service delivery?</p>	<p>individuals or households.</p> <p>To assess the equity of public spending on health and education, the opportunity curve and opportunity index could be used. Using these tools, the RETA will examine spatial disparities in public spending across regions and urban and rural areas.</p> <p>Public expenditure on health and education will be identified at different levels of service provider. Various simulation exercises will be carried out to identify the impacts of public spending on outcomes of health and education, with and without leakage.</p>	
<p>Evaluating Health- and Education-Related Programs and Policies</p>	<p>Did a particular program narrow or widen education and health inequalities? What programs and/or policies have worked or been successful? What programs or policies have not worked? What factors determine success and failure of a particular program or policy? Can conditional cash transfers be implemented in Asia to improve education and health inequalities? Would targeting maximize the impacts of a particular program or policy? What are alternative targeting methods for such programs? How costly is the implementation of targeted versus universal programs or policies such as conditional cash transfers?</p>	<p>The study will review existing education- and health-related policies and programs in selected DMCs. It will employ different budget scenarios and targeting strategies to assess the impact of a particular program or policy on poverty. Moreover, the study will assess whether the outcome of such programs or policies would be pro-poor.</p>	<p>Household surveys and national account statistics</p>

ADB = Asian Development Bank, DMC = developing member country, RETA = regional technical assistance

Figure A2: Public Service Delivery Channels



Source: Asian Development Bank.

COST ESTIMATES AND FINANCING PLAN
(\$'000)

Item	Total Cost
Asian Development Bank Financing^a	
1. Consultants	
a. Remuneration and Per Diem	
i. International Consultants	275.0
ii. National Consultants ^b	105.0
b. International and Local Travel	20.0
c. Reports and Communications	10.0
2. Equipment	5.0
3. Seminars and Conferences ^c	15.0
Technical Panel	5.0
4. Data Purchase	10.0
5. Miscellaneous Administration ^d	5.0
6. Contingencies	50.0
Total	500.0

^a Financed by the Asian Development Bank's technical assistance funding program.

^b Includes remuneration and per diem for research assistants.

^c Includes travel and per diem for workshop participants.

^d Includes publication-related costs, including publication of a book.

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

A. International Consulting Services (15 person-months, intermittent)

1. International consultants (leaders) will be selected and recruited during the implementation of the regional technical assistance (RETA). The consultants should have a strong background in health and education economics, development economics, and/or public finance; experience in understanding and handling micro-unit data is essential. They will be responsible for developing an analytical framework for the individual country studies, and consolidating the findings and experiences of the case studies. The consultants will

- (i) provide guidance and suggest the analytical framework for assessing the delivery of education and health services in selected developing member countries (DMCs);
- (ii) prepare a final draft of the country study report;
- (iii) provide guidance and feedback to the country economists;
- (iv) analyze the issues using appropriate data and analytical models; and
- (v) assist in undertaking the cross-country comparative analysis of service delivery.

B. National Consulting Services

1. Country Economists (35 person-months, intermittent)

2. For each selected DMC, two or three national consultants will be recruited to support the international consultant during RETA implementation. They should have a deep understanding of the respective DMC's economy and broad knowledge of the delivery of public services in which they are assigned to work. In undertaking the country studies, the specialists will

- (i) receive guidance and direction from the international consultant;
- (ii) with the help of an in-country team or research institution, conduct the in-country assessment by (a) assembling relevant country and cross-country data sets to assess current delivery of public services in education and health; (b) reviewing country studies on public service delivery by other international agencies, e.g., World Bank, World Health Organization; (c) reviewing different modes of delivering health and education services; and based on country experience, identify strengths and weaknesses of these methods as applicable; and (d) investigating the effects of devolving administration programs related to health and education on accountability in service delivery; and
- (iii) assist the lead consultant in drafting the case study report and preparing the presentation of the report in the regional workshop or conference.

2. Research Assistants (as needed)

3. Research assistants with a background in economics and strong analytical skills will be engaged to support individual country studies and preparations for the regional conference or workshop. The research assistants will assist in

- (i) collecting and analyzing study-related data,
- (ii) setting up and updating the study website, and
- (iii) preparing presentations and the final report.